The History and Impact of Managed Medical Care in the United States

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The integration of the delivery of health care services with the financing of health care has become known as managed care. Managed health care has a long history in the United States, and currently plays a significant role in the delivery of almost all health and human services in the United States. Managed care began as a strategy for eliminating physician conflicts of interest, but has evolved primarily into an effort to contain escalating health care costs. In an environment where there is fierce competition for human service funding, managed care tools have had a wide impact on patient and client outcomes and on patient and physician and provider satisfaction. This environment and the resulting conflicts will likely continue as health care plans and legislation further evolve.

The history of managed care traces back to the 1930s. Prior to then, patients could choose their doctors and hospitals at will, although they generally lacked the information necessary to make informed choices. Patients, who paid for their own basic medical care, could negotiate the physician’s charges, but professional ethics prevented physicians from advertising services and prices, and little information regarding doctor and hospital evaluations and outcomes was publicly available. Furthermore, a physician shortage existed until 1960, effectively reducing patients’ choice. Traditional fee-for-service practices were rife with conflicts of interests for physicians, as self employed practitioners were actually individual entrepreneurs who bore the risk of profit and loss in their practice. Within fee-for-service practices, physicians have an inherent financial incentive to increase the medical services they supply. Their interest in selling additional services potentially compromises their judgment in assessing patient’s conditions, determining therapy, and managing care. Furthermore, this financing structure actually encourages overutilization of medical services. From 1930 to 1966, managed care techniques largely emerged in the form of Prepaid Group Practices (PPGPs) implemented as an alternative to entrepreneurial physician practices which were viewed by many economists and political leaders as contributing to rising medical services costs and impeding the
desirable growth of a preferred insurance industry. With the introduction of the third part payer, the traditional relationship between the patient/customer and the physician/provider became altered, however, because the patient was not longer involved in the financial transaction of health care and the providers were more assured of payment, regardless of patient outcomes. Primarily, however, PPGPs were developed in an effort to end financial incentives that created physician conflicts of interest, or as an attempt to oversee physician decisions that were often perceived as compromised by conflicts of interest (Rodwin, 2010).

After Medicare and Medicaid were enacted in 1965, the rise in medical spending led lawmakers to seek cost control measures and they increasingly turned away from publicly funded traditional fee-for-service plans in an attempt to contain health care spending acceleration. Although much of the increase in costs have been attributed to factors including technological advances, inflation, the increased needs of an expanding elderly population, longer life spans, and the accelerating costs of medical liability (Saunier, 2011), as medical costs continued to rise in the 1970s, employers sponsoring plans and insurance companies offering coverage began to create new and innovative cost control strategies to stem future increases. “Reacting to a dramatic escalation of health care costs, private and government insurers increasingly shifted from traditional fee-for-service plans to managed care” (Saunier, 2011, p. 22). Managed medical care organizations now include health maintenance organizations (HMOs), preferred provider network organizations (PPOs), point of service (POS) plans which allow patients to choose between network and non-network physicians at the time service is selected, and Integrated Practice Groups (IPGs) of affiliated primary care and specialist physicians. As more managed care organizations have become for-profit entities, they have transformed from a reform-driven movement created to eliminate conflicts of interest in physician decisions into a market-driven profit industry.
Since 1980, managed care organization ownership has consolidated, and managed care and traditional indemnity insurance have become more similar in structure. In place of having distinct models of medical finance and organization, a continuum of medical arrangements has emerged (Saunier, 2011). These arrangements have become known collectively as managed care organizations (MCOs). Today, “the purpose of managed care is to achieve cost control by implementing aggressive cost containment mechanisms” (Saunier, 2011, p. 23).

Managed care tools have been integrated into publicly financed health care (Medicare and Medicaid), into employer and union sponsored plans, and into the individual plans offered to consumers. In contrast to traditional fee-for-services health care which allows doctors to make clinical decisions and bill for their services without input or control from payers or other managers, managed care programs use a variety of tools and interventions, including economic incentives for both doctors (i.e., capitation plans paying set amounts per patient enrolled) and patients (i.e., reduced premiums and deductibles), review of the necessity of various recommended treatments, increased cost sharing in co-payments and doctor capitation, controls on hospital admissions or lengths of hospital stays, and selective contracting with physicians, hospitals and other providers to curtail and contain spiraling medical costs. Managed care is now effectively a “toolbox” and the implements within include utilization review tools (practice guidelines, gatekeeping, health care networks, second opinion requirements, pre-approval requirements) in which medical necessity is determined through the judgment of the provider and the MCOs predetermined criteria; financial incentive tools (doctor payments for performance or by salary instead of fee-for-service payments); and selective contracting which allows insurers to choose which doctors and providers to reimburse for services (Deom, Agoritsas, Bovier, & Perneger, 2010).

These tools have demonstrated success in controlling health care cost escalation, but many patients and physicians view them negatively, believing they have a deleterious impact on important
aspects of medical care, including quality of care, medical practice cost control, professional autonomy, and relationships with patients (Deom et. al., 2010). They found that doctors sampled generally had a more positive perception of cost control tools that were controlled by doctors (utilization review tools) than those that were controlled by the payer (financial incentives and selective contracting), and that older physicians and specialists viewed cost control tools most negatively, while younger physicians and primary care physicians viewed cost control tools more positively. In 1991, H. S. Luft observed that MCOs are highly complex combinations of economic incentives, bureaucratic structures, and personalities.

With respect to patient satisfaction with MCOs, utilization review practices have generated the most controversy. These reviews could be done prior to treatment, concurrent with the treatment, or after the treatment has been received. When post-treatment utilization reviews and coverage denials generated public controversy, most MCOs responded by eliminating the post treatment reviews, instead requiring prior or concurrent reviews.

“Between 1995 and 2001, 47 states passed legislation that regulated managed care, referred to as Patient’s Bill of Rights or Patient Protection Laws. Such legislation represents public management of managed care” according to Rodwin (2010, p. 359). These patient protection laws vary by state, but generally set standards and rules covering the adequacy of provider networks, minimum covered length of inpatient facility stay for certain services, and disclosure of physician incentives. One important provision in these rules is the independent medical review of services when an MCO deems the treatment to be medically unnecessary or experimental and denies coverage. The patient is entitled to appeal the denial of coverage, and the MCO then pays for an independent review organization (IRO) to secure an appropriate physician to evaluate the case. If the IRO decides in favor of the patients, the MCO must cover the cost of the treatment (Rodwin, 2010).
In recent years, MCOs have broadened provider networks, reduced physician risk-sharing, introduced new incentives under pay-for-performance programs, relaxed gatekeeping limiting access to primary care physicians, and concentrated utilization reviews on high cost items. They have increased their focus on the use of pharmaceuticals, overseeing prescribing through utilization review, negotiating discounts with wholesalers, dispensing drugs through mail-order providers, and influencing patient decisions through co-payments. They have also focused on limiting networks for behavioral health care, and regulating their fees and services.

In spite of these changes, in a 2011 review of patient and provider MCO satisfaction, Elliott, Haviland, Orr, Hambarsoomian, & Cleary, found that the satisfaction of beneficiaries in Medicare Managed Care plans was lower than beneficiaries receiving services in traditional fee-for-service Medicare. They also reported that beneficiaries who have lower incomes, are less healthy, older, female, and less well educated report lower satisfaction with quality of care and access to services. Because this population of beneficiaries frequently has more specialized needs, this suggests that more complex cost control tools available in some health care plans may require more attention and communication be directed to vulnerable patients in targeted subgroups in order to provide satisfactory outcomes and minimize patient confusion.

Recognizing that currently the “stated goals of cost effectiveness presume knowledge of measures of health outcomes” (Noble & Klein, 1999, p. 199), the National Council on Quality Assurance (NCQA) suggested developing report cards, evaluation tools and documenting accountability in order to allow MCO beneficiaries to make appropriate decisions between competing plans. They identified four aspects for measurement: access, outcomes, patient satisfaction, and provider satisfaction, reporting to patients, payers, benefit consultants and benefit brokers. Noble & Klein contend that in assessing managed behavioral health managed care organizations, “the environment of care providers in relation to the clients served defines the quality issues of managed
care” (1999, p. 199), and that in behavioral health services as well as all medical and human services, the success of managed care lies in the effectiveness of the system in screening clients, authorizing services and referring to appropriate providers (1999).

In 2006, Alexander & Lantos noted that many Americans now receive their medical care through mixed models of fee-for-service, point of service, and preferred provider networks using different pay structures for in-network care and out-of-network care. Many physicians are now salaried employees of MCOs or are paid based on formal productivity measures. Payment for most hospital care is based on negotiated fee structures using prospective payments. “These changes all resulted from vigorous political efforts, nimble administrative compromises, confusing regulatory mandates, and imperfectly expressed consumer choices” (Alexander & Lantos, 2006, p. 29).

“Continuity between patients and physicians is often considered the cornerstone of the doctor-patient relationship, yet it has been threatened by change in health care organization during the last decade” (Alexander & Lantos, 2006, p. 30). Although many patients express their desire for continuity of the doctor-patient relationship, few are willing to pay additional costs in order to maintain it. The growth of the hospitalist physician role in health care delivery illustrates this reluctance to pay more to preserve continuity in the doctor-patient relationship, with only 20% of patients willing to pay an additional $250 to cover the charges of receiving inpatient hospital care from their primary physician. The remaining 80% of surveyed patients were willing to pay only an additional $34 to ensure continuity of care while hospitalized from their primary physician. They concluded that “the doctor-patient relationship is both an icon and a reality. It is often valued more in rhetoric than in practice by both doctors and patients” (Alexander & Lantos, 2006, p. 31).

Summarizing the changes that managed care has brought to medicine, Alexander & Lantos note that as we spend more on health care and achieve better outcomes by doing so, we seem to become ever more dissatisfied with our healthcare system (2006). “Managed care may allow choices that offer
patients more options and allow them to select health care plans based on price, quality, location, and other factors. In its ideal form it may allow for better population-based care, reduce the use of unnecessary tests and procedures, and allow doctors the time to provide higher quality primary care. In doing so, however, it may force patients to explicitly trade-off cost for continuity. Increased freedom may lead to decreased satisfaction. And most managed care is not practiced in its ideal form” (Alexander & Lantos, 2006, p. 31).

It is clear that as health care continues to change in the United States, patients, providers and organizations will always continually be required to adapt. Managed care has wrought significant changes during the past 80 years, and with the Passage of the Affordable Care Act in 2010, many health care plans will need to undertake significant changes in order to become and remain fully compliant with the new legislation, creating accountable care organizations (ACOs) that are responsible for patient outcomes and health. The legislation will also challenge the capacity of the system, as all U.S. citizens will be required to acquire appropriate healthcare insurance coverage or pay a substantial penalty. These and other challenges will represent an opportunity for MCOs to create further innovative cost containment measures within their plans.
References


